Psychiatric Medication Consent Form

Patient Name:

Date of Birth:

Date:

Medication Information

Medication Name(s):

Prescribed Dosage/Frequency:

Purpose of Medication

Possible Benefits

Possible Risks/Side Effects

Alternative Treatments

- [ ] I have read and understand the above information.
- [ ] My questions have been answered.

☐ I give my consent for the administration of the above medication(s).

Patient Signature:

Date:

Provider/Witness Signature:

Date: